BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x 700**

Please refer to your Administration Kit for enrollment and mailing instructions

REFUSAL OF INSURANCE

Employee Name *(Last, First, Middle)* | Employer/Policyholder | Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with whom I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ All Coverages ☐ Life & AD&D ☐ Dependent Coverage ☐ STD ☐ LTD ☐ Dental ☐ Vision

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company. If I desire to participate in the dental program at a later date, additional benefit type waiting periods may apply.

Signature of Employee _____ SSN # _____

Signature of Witness _____ Date _____